



Pacific Northwest Cross Connection 2012 Participant Registration & Health History Form

Camper Information

Name _____ Birth date _____ Age _____

Preferred Name _____ Gender _____ Grade entering in fall _____

Mailing Address _____

City _____ State _____ Zip _____

Telephone (home) (____) _____ e-mail _____

Parent 1 Name _____ Parent 2 Name _____

Parent 1 Work _____ Parent 2 Work _____

Parent 1 Cell _____ Parent 2 Cell _____

Child lives with (circle one): Parent 1 Parent 2 Both Guardian

Emergency Contact _____ Phone (____) _____ Relationship _____

Additional adults authorized to pick up my child:

Adults NOT authorized to pick up my child:

Cost

Deposit- \$100 per camper

\$250 per person total

Dates

Sunday, June 24th Check-in at 3pm

Friday, June 29th Check out at 11am

Payment Information

Deposit (\$100/ camper) must accompany registration form to reserve a place in the chosen camp session.

Total Events Cost \$ _____ Charge \$ _____ to my MASTERCARD, VISA or DISCOVER Card (circle one)

Scholarship Donation \$ _____ Card # : _____ - _____ - _____ - _____ Exp ____/____

Amount Enclosed \$ _____ *Signature* _____

Remainder Owing \$ _____ *If paying by credit card, full payment is required at time of registration.*

Camp Scholarship Amount \$ _____ Scholarship Source Name _____

Scholarship Source Official _____ Phone (____) _____

Make checks payable to:
Twinlow Camp

Scan and email or Mail completed forms with Payment:
Twinlow Camp
22787 N. Twinlow Rd.
Rathdrum, ID 83858
office@twinlowcamp.org

Camper Name: _____

Insurance Information

Insurance Carrier or Plan Name _____ Group# _____

Name of Insured _____ Relationship _____

Insurance ID or Policy # _____

Name of Family Physician _____ Phone (____) _____

Current Health Conditions Please describe any current health conditions requiring medications, treatment, or special restrictions or considerations while at camp.

Past Medical Conditions/Health History Please describe past medical treatment, (i.e., surgeries, heart conditions, fainting, seizures, etc.) or other medical concerns.

Immunization Record

Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		____	____	____	____	____	____
TD (tetanus/diphtheria)		____	____	____	____	____	____
Tetanus		____	____	____	____	____	____
Polio		____	____	____	____	____	
MMR		____	____				
Haemophilus influenza B		____	____	____	____		
Hepatitis A		____	____				
Hepatitis B		____	____				
Varicella (chicken pox)		____	____				

Allergies List all known allergies including those involving medication, food, insect, asthma, hay fever and other allergies. Please describe reaction and management.

ALLERGY

REACTION AND MANAGEMENT

Camper Name: _____

Medications Please list ALL medications (including over-the-counter or non prescription drugs) taken routinely.

Keep medications in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. Please be advised that all medications must be turned in to the Camp Health Care Provider prior to camper arrival.

NO Medications on a routine basis

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking: _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking: _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking: _____

Health Care Recommendations by Licensed Medical Personnel

A physical exam and physician's signature is recommended, but not required, for camp attendance.

I examined this individual on _____.

In my opinion, the above applicant is _____ is not _____ able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions (include treatment to be continued at camp).

Comments

Physician's Signature _____ Phone (____) _____ Date _____

Special Needs/Restrictions:

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary) and provide any information that will enable us to create a healthy, helpful environment for the camper. Please include: recent injuries or illnesses, medical conditions requiring treatment, behavioral/learning challenges and suggested disciplines, emotional needs/concerns, hearing impairments, visual impairments, special routines. (Attach additional page, if necessary.) Include dietary restrictions other than allergies mentioned above.

Parent/Guardian Authorization

I, the undersigned parent/guardian, give permission for the above named camper to participate in the camp indicated above. I recognize and acknowledge that camping activity can involve certain hazards, including, but not limited to, illness, injury and accidents, and release Twinlow Camp and The United Methodist Church from liability. I either have appropriate insurance or, in its absence; agree to pay all the costs of medical services as may be incurred on my camper's behalf. I give permission for:

- Standard medical treatment according to Camp Physician Standing Orders.
- Emergency medical treatment in the case that I cannot be contacted
- Administering physician prescribed medications
- Release of information for insurance purposes
- Transportation for scheduled off-site events
- Photos used for publicity

The health history is accurate and complete as far as I know.

Signature of Parent/Guardian _____ Date _____